

IMPLEMENTING A STATEWIDE EARLY CHILDHOOD MENTAL HEALTH CONSULTATION APPROACH TO PREVENTING CHILDCARE EXPULSION

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ABSTRACT: State- and local-level mental health administrators and practitioners can work collaboratively to provide effective early childhood mental health consultation (ECMHC) services that address the growing need in communities to promote healthy socioemotional functioning in infants and young children and prevent longer term mental health challenges. This article describes one state's model of ECMHC, the Child Care Expulsion Prevention Program (CCEP), as well as preliminary evaluation findings on consultants' fidelity to the developed approach to service within 31 counties in Michigan. The CCEP approach is flexible, yet adheres to six cornerstones which are essential to effectively and consistently carrying out services across local projects, including the provision of relationship-based programmatic and child/family-centered consultation, hiring and supporting high-quality consultants through professional development and reflective supervision, ongoing provision of state-level technical assistance, use of evidence-based practices, and collaboration with other early childhood service providers. In addition to the overview of CCEP's approach and effectiveness, lessons learned are provided to guide those engaged in policy development, practice, and applied research pertaining to ECMHC.

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Rates of expulsion in preschool children (27.42 per 1,000 students) are substantially higher than are rates of expulsion in school-aged children (.80 per 1,000 students) (Gilliam, 2005). Expulsion

from childcare is a drastic response to challenges that emerge and represents a profound breakdown of the person–environment fit. The reasons for this breakdown are often complex, but many times are associated with challenging child behaviors such as aggression and regulatory concerns, caregiver variables such as stress and lack of child behavior management skills, or characteristics of the childcare setting such as a chaotic environment or a lack of routine. State-funded childcare programs with access to psychologists/social workers reported preschool expulsion rates almost half the number of those programs that lacked access to consultation services (Gilliam & Shahar, 2006). Access to ECMHC serves as an important resource for programs and caregivers [e.g., childcare providers, parents; throughout this article, parents may refer

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to biological/adoptive parents, grandparents, aunts, uncles, foster parents, or any other steady presence in the child's life within the child's home(s) who are struggling to meet the socioemotional needs of their children.]

ECMHC involves a collaborative, problem-solving approach that attempts to improve child outcomes through the involvement of those who provide direct care to the child, building sustainable changes in care-giving practices. ECMHC has been identified as a specific approach to prevent preschool expulsion and a means to promote successful social, emotional, and behavioral outcomes in young children. The use of consultation to providers and parents is a valued approach to the delivery of infant mental health services to at-risk populations (Beeber et al., 2007; Summers, Funk, Twombly, Waddell, & Squires, 2007). Consultation is believed to be a cost-effective approach (Upshur, Wenz-Gross, & Reed, 2009), often justified as a way to prevent the extraordinary costs associated with treating behavioral problems at a later point within the life of a child (e.g., mental health services, juvenile justice system). ECMHC has been found to impact staff (e.g., improvements in providers' self-reported competence), program (e.g., reductions in program expulsions), and child outcomes (e.g., reduction in externalizing behaviors) (Brennan, Bradley, Allen, & Perry, 2008; Perry, Allen, Brennan, & Bradley, 2010). Although these findings are positive, inconsistency among studies calls into question for whom and under what conditions ECMHC leads to improved child, provider, family, and program outcomes (Gilliam, 2007).

Attempts to isolate the essential components of effective ECMHC have emerged within the past decade. Results from a critical review of six ECMHC programs identified three core program components—a solid infrastructure, highly qualified consultants, and high-quality services—and two essential catalysts for success—high-quality relationships between consultant and consultee, as well as providers and parents who are motivated to change existent practices (Duran et al., 2009). These components complement those summarized in an earlier report that identified the essential factors as (a) the need for a collaborative relationship, (b) the importance of problem-solving and capacity-building goals within consultation, (c) the need for clear definition of the problem within a time-limited approach, and (d) the involvement of consultants who possess a set of specific skills and competencies (Cohen & Kaufmann, 2005). The single most important ingredient of ECMHC is reported to be the ability of the consultant to develop positive collaborative relationships through effective interpersonal communication with program staff (Green, Everhart, Gordon, & Gettman, 2006). The field of infant mental health also has identified relationships to be essential in promoting optimal growth and change (Weatherston & Osofsky, 2009).

The purpose of this article is to describe the development, implementation, and statewide supports that are in place to ensure the fidelity of an ECMHC program in Michigan called the *Child Care Expulsion Prevention Program* (CCEP). Efforts to sustain and improve the program through close examination of methods and infrastructure supports that insure implementation fidelity are addressed. Specific attention is paid to the involvement of key

stakeholders in carrying out the program as intended and a close examination of the continuous quality-improvement plan that guides the program. Table 1 highlights how CCEP meets Duran et al.'s (2009) essential components for effective ECMHC and provides insights into program-development considerations that may be of interest to those seeking to develop these services within their own communities. The article is informed by quarterly report data collected by each program on services provided, via an online survey completed by the 29 CCEP consultants in 2008 about practices and experiences in providing CCEP services (Van Egeren et al., 2009; Van Egeren et al., 2008) and preliminary data from a 3-year evaluation of CCEP services to more than 350 providers/families.

BACKGROUND AND HISTORY OF CCEP

In the late 1990s, a needs assessment conducted by the Michigan Department of Community Health (MDCH) led to the initial development of the CCEP as a means to prevent childcare expulsion and increase children's socioemotional success. Efforts to scale up the CCEP project to function as a statewide approach to prevention occurred through the efforts of key state-leadership personnel during the past decade. By 2008, the MDCH administered 16 CCEP projects across the state that were funded by the Michigan Department of Human Services (MDHS) using earmarked discretionary dollars from Michigan's federal Child Care and Development Fund. As of fiscal year 2009, funding varied from \$71,400 to \$213,925 per local project, depending on the proposal submitted for funding and the scope of each project, with a total state investment of \$1,852,992. This amount included \$125,000 for evaluation purposes. The CCEP serves children (birth to age 5 years) attending childcare that is licensed, registered, or provided by relative care providers and daycare aides enrolled with the MDHS. Priority for service is given to infants and toddlers who receive the MDHS Child Development and Care subsidy.

STATE-LEVEL STAFFING, QUALIFICATIONS, AND RESPONSIBILITIES

State-level grant management is provided by a Grant Manager employed by MDHS. The Grant Manager is a strong supporter of the program and integrally involved in CCEP development and improvement, and meets regularly with state- and local-level program staff on a quarterly basis, responding readily to contractual questions. State-level administrative, contractual, and budgetary oversight of the CCEP is provided by the MDCH's Division of Mental Health Services to Children and Families. The division director serves as the MDCH Administrator for the CCEP. She is an avid champion for early childhood mental health at the state level and is actively involved in reviewing program operations across the 31 counties. She negotiates and manages contracts and works collaboratively with the other state-level staff. Two state-level staff, a full-time CCEP Program Director (CCEP Director) and a part-time CCEP Technical Assistance Coordinator (CCEP TA Coordinator),

TABLE 1. Key Facets of Effective ECMHC Program Infrastructure and Comparable CCEP Elements

Effective Infrastructure (Duran et al., 2009)	CCEP Elements
Strong Leadership	<i>State-Level Leadership:</i> MDHS State Grant Manager, MDCH Administrator, CCEP Director, CCEP TA Coordinator, and State Partners Advisory Team <i>Local-Level Leadership:</i> CCEP Supervisor and local CCEP Community Advisory Team
Clear Model Design	Six Cornerstones to CCEP which guide the local contractual language, standardized forms, and data-collection procedures, standardized orientation to CCEP, ongoing technical assistance on policy and procedures, standardized marketing materials, clear service population: <ul style="list-style-type: none"> • Children birth up to age 5 years • Children in MDHS licensed or registered childcare or being cared for by an MDHS enrolled relative care provider or daycare aide • Priority for service given to infants and toddlers receiving subsidized childcare
Clear Organizational Structure	MDHS provides state-grant management; MDCH provides state-grant administration and subcontracts with 16 community mental health agencies which employ consultants across the state, and each agency is accountable to the CCEP's central management team. Further, each consultant is jointly supervised by his or her respective subcontracting (i.e., hiring) agency.
Hiring and Training Highly Qualified Consultants	<i>Hiring:</i> Local contracts require hiring of consultants with a master's degree; Michigan Association for Infant Mental Health Endorsement at a minimum Level II; 2 years of infant and early childhood mental health experience, knowledge of early childhood development; cultural competence; warm/empathic personalities; excellent communication skills; experience in childcare setting, social emotional assessment; experience training <i>Training:</i> CCEP orientation, CCEP quarterly TA meetings, CCEP monthly TA conference calls
Supervision and Support Mechanisms	Ongoing administrative and reflective supervision (required 24 hr per contract year; e.g., 2 hr/month) to ensure the quality and the fidelity of the CCEP approach
Strategic Partnerships	CCEP State Partners Advisory Team (state-level members from: MDHS, Early Childhood Investment Corporation, Head Start State Collaboration Office, MSU Extension, and Child Care Resource and Referral)
Community Outreach and Engagement	CCEP projects provide ongoing socioemotional training; consultants attend and present at local conferences, participate in early childhood collaborations, coordinate groups within the community; community stakeholders are invited to be part of local CCEP project advisory teams
Clear Communication	CCEP's State Team communicates regularly with local consultation service providers via monthly conference calls, quarterly onsite meetings, e-mail, TA resource documents, quarterly reports from the local program sites to monitor cases and integrity of services provided, and periodic site visits and standardized contractual language.
Evaluation	Quarterly data reporting and rigorous outside evaluation; results used to make quality improvements and insure quality of CCEP implementation
Financing	MDHS using Child Care Development Fund Dollars targeted for infant/toddler quality improvement (Fiscal Year 2009: \$1.85 million)

MDHS = Michigan Department of Human Services; MDCH = Michigan Department of Community Health; CCEP = Child Care Expulsion Prevention Program; CCEP TA = Technical Assistance Coordinator; TA = technical assistance; MSU = Michigan State University.

work collaboratively with the MDCH Administrator to provide day-to-day monitoring and direction to the 16 CCEP projects. The CCEP Director's primary responsibilities include (a) ensuring that projects are meeting contractual obligations; (b) providing regular onsite, e-mail, and telephone consultation to local projects; (c) participating in state-level committees and meetings related to infant and early childhood services; (d) collecting quarterly data from projects and disseminating the information for quality improvement; (e) co-hosting quarterly, onsite meetings for all projects and monthly technical-assistance conference calls; and (f) providing ongoing training to project staff on assessment, socioemotional health, and the CCEP model. The CCEP TA Coordinator's primary responsibilities include (a) coordination of an e-mail group of over 300 members across the state, (b) development of needed materials and program policy for projects to help with their success, and (c) facilitation and organization of technical-assistance activities.

Prior to the hiring of these two state-level staff, the MDCH Administrator recognized the importance of building a strong pro-

gram infrastructure from which a high-quality, relationship-based ECMHC program could develop and expand across the state. With that purpose in mind, it was determined that the CCEP leadership staff would need to possess the following qualifications and characteristics: (a) master's degree in psychology, social work, or the human services field, (b) extensive experience and success in program development and providing technical assistance, (c) skills and competency in infant and early childhood mental health, (d) passion and commitment to the program mission, (e) ability to work as a team member, and (f) knowledge of and experience with early childhood systems. Both the CCEP Director and the CCEP TA Coordinator hired met these qualifications and have been long-standing staff members throughout this program's history.

The CCEP TA Coordinator and the CCEP Director co-attend state-level trainings related to early childhood mental health services and have systems in place to continually improve and share their knowledge base of best practice. They talk weekly to problem-solve and support CCEP implementation. This close collaboration

leads to consistent messages going to the local projects. The communication loop that exists between and among the state-level staff (i.e., Grant Manager, MDCH Administrator, CCEP Director, and CCEP TA Coordinator) and local-level staff (i.e., CCEP consultants and CCEP project supervisors) has been reported by many within the CCEP to model the value and importance of relationship-based systems within ECMHC. This communication loop and the frequency of meetings help to address issues of implementation and fidelity to the six CCEP cornerstones.

DEVELOPMENT OF THE CCEP APPROACH TO ECMHC

The CCEP conceptualizes ECMHC as part of an early childhood system of care that promotes socioemotional well-being, prevents socioemotional problems among at-risk children, and identifies and treats mental health problems among children from birth to 5 years. The CCEP promotes knowledge of socioemotional health through consultation and focuses on the prevention of infant, toddler, and preschool expulsion and other long-term, socioemotional challenges for children. Michigan's approach to ECMHC does not include the provision of direct therapeutic-intervention services, meaning that universal promotion and prevention efforts as described within the "Teaching Pyramid Model" of socioemotional-competence promotion (Perry & Kaufmann, 2009) are the primary focus of this service-delivery approach. As a structured component of CCEP service delivery, those children who are assessed to need more intensive, individualized services are referred by consultants to community-based partners, who then provide those intervention services.

Relationship-based practice is the fundamental approach of the CCEP. Practitioners facilitate and nurture optimal adult-child interactions by building trusting relationships with parents and providers. This relationship mirrors or serves as a model for the types of interactions that need to be fostered among parents and providers and between these adults and the child. The relationship-based approach provides a safe foundation for growth and change to occur (Parlakian, 2002; Weatherston & Tableman, 2002).

The CCEP approach to ECMHC allows for a considerable level of flexibility in practice across a diverse set of communities while also highlighting the importance of a core foundation for practice to which all projects adhere. Specifically, six cornerstones are central to providing and maintaining high-quality CCEP services; the first four set the framework for quality practices, and the last two relate to services provided. These cornerstones entail: (a) required qualifications and ongoing professional development for CCEP consultants, (b) provision of regular and consistent supervision for CCEP consultants, (c) required participation in state-level technical assistance for CCEP consultants and supervisors, (d) collaboration with local early childhood partners, (e) provision of child/family-centered and programmatic consultation, and (f) emphasis on the use of evidence-based tools. These six cornerstones serve as the basis for contractual language between the MDCH and local Community Mental Health Services Programs (CMHSPs).

HIRING, PREPARING, AND SUSTAINING HIGH-QUALITY CONSULTANTS

The MDCH contracts with county/regional CMHSPs to implement CCEP projects. CCEP consultants are employed in a variety of ways: directly by the CMHSPs (41%), by an agency that sub-contracts with the CMHSP to provide services (31%), or as an individual contractor with the CMHSPs (27%). Most of the projects have a designated supervisor and, at a minimum, one full-time consultant position.

To provide high-quality services, the CCEP is required to hire mental health professionals with special qualifications that enable them to address the complex issues faced by the service population. Per contractual obligations, consultants must have a master's degree in social work, psychology, or a related field and must have the Michigan Association for Infant Mental Health Endorsement (Weatherston, Kaplan-Estrin, & Goldberg, 2009) at Level II, III, or IV. Additional qualifications that are expected for consultants are (a) 2 years of experience as a mental health clinician specializing in relationship-based work with young children and their families; (b) knowledge of infant and early childhood development (0–5 years), particularly socioemotional development; (c) experience with socioemotional assessment; (d) experience working in childcare settings; (e) experience providing training and facilitating groups; (f) warm, empathic personality and excellent communication skills; and (g) cultural competence. On average, based on 2008 survey data, consultants had a range of 2½ to 30 years of experience in providing early childhood mental health services. Three quarters of consultants had worked in the field for at least 10 years. Most consultants (83%) were licensed as social workers, psychologists, or professional counselors. This level of expertise is viewed as crucial to offering quality, relationship-based, family-centered, and prevention-focused CCEP services.

Once they are on the job, consultants are prepared to provide CCEP services through program-orientation procedures and ongoing technical assistance, and by shadowing experienced consultants (i.e., more than 2 years providing CCEP services within a project). Initial orientation to CCEP policies and practices is carried out via regular one-on-one visits; onsite, day-long training; and conference-call webinars. A standardized approach to carrying out CCEP services is shared with consultants as a part of orientation. This includes dissemination of a CCEP binder, which includes program information pertinent to ensuring the fidelity of the consultation process, including the local contract, chapters outlining best-practice consultation processes, and data-reporting forms and specific instructions and guidance about carrying out a data-based approach to ECMHC. This binder supports the provision of a structured approach to delivering CCEP services and helps to maintain the fidelity of the program through its use by all statewide consultants. Consultants also have access to regular onsite, quarterly meetings pertaining to implementing the program and identifying barriers to following through with any aspect of the CCEP process. Mental health training is offered as part of these meetings on topics such as "Family-Centered Practice in ECMHC," "Infant and

Toddler Social and Emotional Strategies,” and “Medicaid Access Criteria and Services for Young Children.” Consultants also participate in monthly, statewide technical-assistance calls involving state- and local-level CCEP staff to focus on skill development and follow through with delivering CCEP services as intended.

Regular supervision of consultants is an essential component of the CCEP and critical to maintaining and adequately supporting the consultant workforce. Accordingly, all CCEP contracts with local CMHSPs include a stipulation that each consultant must have access to regular, ongoing administrative and reflective supervision. The amount of time designated for a supervisor’s time ranges per project from .05 to .25 of a full-time employee position. Administrative supervision sessions focus on the oversight of state, agency, and program regulations and procedures as well as clinical discussion around cases. Frequency and duration of administrative supervision of consultants varies, but typically happens every other week for a minimum of 1 hr.

Reflective supervision provides consultants with opportunities to communicate with their supervisor individually and target specific issues that occurred during consultation services. This provides consultants the chance for confidential reflection and feedback. Both supervisor and supervisee are active participants in listening and engaging in thoughtful questioning. Reflective supervision is a hallmark of the Infant Mental Health model (Gilkerson, 2004). The trusting relationship that develops between a supervisor and a consultant/provider is effective in reducing feelings of isolation, promoting personal and professional reflectivity in working under challenging circumstances, and increasing reflectivity about ECMHC practices (Heffron, 2005). CCEP contracts require consultants to engage in a minimum of 24 hr of one-on-one reflective supervision within the fiscal year (i.e., an average of 2 hr per month). Reflective supervision must be provided by individuals who are knowledgeable about ECMHC, infant mental health, and childcare practices. If the administrative supervisor is unable to provide reflective supervision, then the CMHSP contracts with a private practitioner to provide this service.

In practice, survey results from 2008 have indicated that consultants who received one-on-one reflective supervision were most likely to participate every other week or once per week. A small minority of part-time consultants (17%) and full-time consultants (7%) received individual reflective supervision less frequently than every other week. Typical one-on-one reflective-supervision ranged from 60 to 120 min. Time spent tended to be shorter when reflective supervision occurred more frequently. However, projects may have difficulty finding professionals who have the credentials and experience to provide reflective supervision. In Michigan, this was true in some of the more rural, less populated areas. Efforts have been made in conjunction with the Michigan Association for Infant Mental Health to prepare more individuals for this type of work and to better link agencies with prepared supervisors. In some cases, a number of sessions were provided via the telephone when travel was not possible due to weather or budget challenges. This practice was an exception, and special permission was given to the local project from the state-level staff.

TECHNICAL ASSISTANCE AND CONTINUAL QUALITY IMPROVEMENT

State-level technical assistance was put into place early on to facilitate CCEP fidelity and ensure that local projects received the support needed to do consistently high-quality work. Technical assistance is provided via quarterly meetings, monthly calls, onsite visitation, an e-mail group, and by telephone. Required in-person quarterly meetings are held in a central part of the state and include at least one staff member from each CCEP project. Typically, all CCEP consultants and their supervisors attend. These all-day meetings involve state-level information and resource sharing, specialized training for consultants, and time for small-group reflection on “hot” topics such as “How to engage relative providers,” “Strategies that support self-regulation,” and “Involving families in consultation.” Conference calls are held each month in which there is no quarterly meeting; these calls last at least 90 min. The CCEP Director and the CCEP TA Coordinator facilitate discussions pertaining to state updates, contractual obligations, and any other topics related to ECMHC. The CCEP Director also does onsite visits to CCEP projects to provide additional help with local program development. This often includes helping projects develop a data-collection system, brainstorming ways to do outreach to the community, and reviewing quarterly progress. Project staff can e-mail or call the CCEP Director or the CCEP TA Coordinator to ask questions or give feedback on policy and procedures. Consultants’ community-based experiences are instrumental in developing and maintaining CCEP services that best meet the needs of the children, providers, and parents served. Consultants’ recent feedback on the array of CCEP technical-assistance activities offered have indicated that quarterly, onsite technical assistance meetings were rated as most helpful. Onsite visits and telephone consultations also were viewed as essential to professional development and continuous improvement in providing high-quality CCEP services. These results suggest that personal and individualized communications and support were the most helpful form of technical assistance.

As part of contractual obligations and for ongoing quality-improvement purposes, each CCEP project completes an extensive online, quarterly report on progress toward annual goals, services provided, outcomes for children, frequency and duration of services, involvement in technical-assistance activities, frequency of supervision, and any other information that projects may wish to share regarding CCEP implementation. A standard set of forms to collect data for this quarterly report are completed by projects. The CCEP Director compiles this data to create a comprehensive program report for the Grant Manager and MDCH Administrator. Information gleaned from the report also guides future training opportunities and reflection during onsite, quarterly meetings and monthly conference calls. This continual feedback assists with ongoing communication and enhancement of collaborative relationships between state- and local-level CCEP staff. Moreover, this feedback loop has resulted in significant improvements to CCEP processes and procedures since its inception.

STRATEGIC COLLABORATION TO IMPROVE AND SUSTAIN SERVICE DELIVERY

Collaboration is a critical piece of the CCEP's success. Relationships with other early childhood service providers have clearly resulted in emergent policies and funding to expand the availability of ECMHC for young children and their families. Partnerships have been most productive when relationships are nurtured through regular, in-person meetings. The CCEP's state partners include the MDHS, the MDCH, the Head Start State Collaboration Office, state-level University staff, the State Child Care Resource and Referral Association, and the Early Childhood Investment Corporation (ECIC). The ECIC is a statewide public/private partnership initiated by the governor's office, which brings together the corporate sector, government, and foundations to build a comprehensive early childhood system. The CCEP state-level staff meet quarterly with these state partners to discuss program progress. The CCEP's MDCH Administrator co-chairs the ECIC Social-Emotional Health External Board Advisory Committee. The CCEP's Director and TA Coordinator are active members. This committee advises the ECIC Executive Committee regarding plans to enhance the socioemotional care and development of young children within the state.

At the local level, early childhood partners and families are critical to successfully integrate a CCEP project within a community. Each CCEP project has a community advisory committee, which includes parents and early childhood service providers. These committee members support the implementation of the CCEP by publicizing, providing guidance, and making referrals to and from the project. It has been critical that the CCEP projects work collaboratively with other agencies that have established relationships with childcare programs, such as Child Care Resource and Referral agencies, Part C and education staff, and Head Start/Early Head Start staff.

CCEP CHILD/FAMILY-CENTERED CONSULTATION

The primary goal of the CCEP child/family-centered consultation is to assist the family and childcare provider to successfully nurture the socioemotional development of an infant or young child who is exhibiting challenges in childcare to prevent expulsion and ensure that the child has a positive childcare experience. According to internal system-monitoring procedures, children are referred to CCEP services primarily for problems related to aggression (e.g., biting, hitting), developmental delay (e.g., language or social delay), and concerns pertaining to self-regulation (e.g., impulsivity, difficulty calming down when upset). The consultant works jointly with the family and provider to identify and address the reasons underlying the challenging behavior. Consultants work from an ecological perspective, taking into account multiple factors pertaining to the child, the child's family, the childcare environment, and the child's community. Perhaps the most important role the consultant has in child/family-centered consultation is to serve as the voice of the child, suggesting how the child's challenging be-

haviors are a function of environmental stressors or the result of unmet needs within the childcare setting rather than as an indication that the child is inherently "bad" or solely responsible for the identified problem (Weatherston, 2000).

Consultation is initiated primarily by the childcare provider and takes place in the childcare setting and in the home. On average, 75% of consultation occurs at the childcare site, and 25% occurs within the child's home. It is intended that families are always kept aware of and included in childcare consultation. Full-time consultants' caseloads typically range from 8 to 15 child/family-centered consultation cases at any one time. The number of contacts with parents and providers per child varies greatly, mainly based on the severity and complexity of the presenting challenges. The amount of time or the number of visits necessary to build a trusting relationship with the parent and provider also is an important determinant of the length of consultation. The CCEP has no set number of visits per case, unlike other ECMHC approaches (Gilliam, 2007).

The average length of CCEP child/family-centered services tends to vary and typically is between 3 to 6 months. Recently summarized outcome-evaluation results involving more than 350 children/families who used CCEP services indicated that child-centered consultation cases lasted an average of 4.7 months. Consultants were engaged in an average of 11.1 ($SD = 9.1$) hr of face-to-face contact per case. Providers were engaged in these face-to-face contacts an average of 2.5 hr more than were parents, but considerable variability in time spent was found. Consultants reported that typical visits range from 1 to 3 hr, suggesting that substantial differences exist among consultants in their approaches to visits. This, as reported by consultants through informal discussions, is in part due to the variability in needs of the childcare setting, the child, and the family. Despite the considerable variation in duration and frequency of visits, six specific steps are recommended within the CCEP approach to child/family-centered consultation. These steps have become an integral part of the CCEP approach and were developed through multiple years of observation, data collection, and discussion between consultants, supervisors, and state-level staff regarding best practice methods for supporting children and families. The steps include:

1. referral, intake, and consent
2. observation (within the childcare and home settings) and assessment (child and environmental)
3. meeting to develop a Positive Child Guidance Plan
4. provision of ongoing support for the family and provider to implement the Positive Child Guidance Plan
5. referrals to outside services as needed
6. conclusion of services.

Each of these sequential steps addresses how a child/family-centered case typically unfolds, yet data have revealed that such an orderly manner in real life varies from case to case and that not all activities are necessary or appropriate in all situations. For example, a consultant may work with a family and a childcare

provider on behalf of a child through intake and observation and then the family might move, so the additional process steps may not take place. Evaluation results on the CCEP and practices revealed that consultants reported that approximately 91% of child/family-centered consultation referrals went through the referral, intake, observation, and assessment steps. Of those 91% cases that went through this initial phase, approximately 72% went on to the development and implementation of a Positive Child Guidance Plan, a summary of the planning process involving goals and strategies that are developed based on identified strengths and weaknesses surrounding the case. The remaining 28% of cases that did not have a formal plan and ongoing CCEP consultation to support the plan typically had been referred to other services (e.g., speech and language, Part C, special education, Head Start) or had dropped out of services (e.g., family moved, family lost job and could not afford childcare, family got a job elsewhere). Fifty-eight percent of cases with Positive Child Guidance Plans and continued consultation support participated in a formal conclusion of services, which included a final, face-to-face meeting between the consultant, the family, and the childcare provider to discuss transition plans and to complete final data forms (i.e., satisfaction surveys).

Some programs optionally provide follow-up services by checking in with providers and families several months after services have been concluded, though no recent evaluation data were obtained regarding this step. In sum, these data help to illuminate those areas where fidelity of the CCEP model is strong and other places where further improvements in the approach are needed. In addition, the data provide a sense of how the process varies across consultants and cases within this ECMHC approach to prevent childcare expulsion.

CCEP Programmatic Consultation

The primary goal of CCEP programmatic consultation is to improve the socioemotional quality of a childcare program and/or assist the program to address a classroom or program-wide issue that affects more than one child, staff member, and/or family member. In programmatic consultation, the consultant generally works with staff (and families in certain circumstances) to evaluate specific challenges and identify concerns, and then create a plan to address them. The primary role of the consultant in programmatic consultation is that of a facilitator who encourages everyone involved to participate and share different perspectives without fear of being interrupted or judged. Childcare providers have often stated that after working through a programmatic consultation process with a CCEP consultant, they have become more capable of responding to other challenging situations. Programmatic consultation typically involves all staff in a childcare setting.

All CCEP programmatic consultation involves five steps:

1. a request for programmatic consultation
2. observation and assessment
3. developing the Programmatic Action Plan

4. support for implementing the plan
5. conclusion of services.

Project staff may optionally follow up with childcare programs after services end to check on sustainability of change. Recently summarized CCEP evaluation results have indicated that the most common programmatic consultation activity was to build supportive relationships between childcare providers and families and childcare providers and children. Another common activity was helping to infuse a more structured daily routine, including coaching the provider on using visual supports throughout the care setting. Improvements in daily routines were typically accomplished by creating a flexible, yet dependable, daily schedule that supports the various needs of young children and using best practices to support transitions throughout the day (e.g., a song to indicate cleanup time). Duration and frequency of visits related to programmatic consultation vary. On average, consultants' reports from the 2008 survey indicated that programmatic cases ranged from 3 to 6 months in length. Childcare programs were visited approximately once a week, with visits lasting 1 to 2 hr. Over time, as a plan was put into place, the frequency of visits lessened. Most often, programmatic consultation is intertwined with a child/family-centered case, and strategies to improve program practices are embedded into a Positive Child Guidance Plan, thereby accounting for frequency and duration averages mirroring those of child/family-centered consultation. In cases where programmatic consultation happens for sites outside of child/family-centered consultation, the average length of service is similar to child/family-centered services, averaging 3 to 6 months, but in some cases going longer depending on the needs and quality level of the childcare setting. The childcare center enters into an agreement for services, and consultation steps are followed, but no set number of visits is recommended to allow for flexibility in services.

Programmatic consultation nearly always occurs in conjunction with a child/family-centered case. In almost all CCEP consultation cases, the consultant is already working with the provider to assist a particular child. As relationships are built through child/family-centered consultation, consultants often suggest strategies for programmatic enhancement within the childcare setting as an adjunct to services. In this situation, the intake is conducted very informally, and the programmatic support occurs alongside child/family-centered services. Occasionally, a childcare director or staff will call to inquire about programmatic consultation separate from a child/family centered referral. For example, a director might call a CCEP consultant and say "My transition times are really hard" or "Nap times are a disaster." This type of request is quite rare: For example, in the 2009 CCEP annual report, local projects reported serving 378 childcare centers. Eighty-three percent of those centers received programmatic consultation precipitated by a child/family-centered case, and the other 17% received programmatic consultation in isolation of a child/family-centered referral. Once a child/family case is begun and a relationship is built, programmatic strategies are built into the child's Positive Child Guidance Plan, supporting the child's skills as well as other

children in the care setting. For example, for a child struggling with transition, a visual schedule may be put into place, which may directly help the daily routine of the class as a whole. It is typical that virtually all Positive Child Guidance plans include programmatic strategies (e.g., infusing conflict-resolution steps into the classroom, using social stories to teach social skills) that are of benefit to all children because one of the critical goals of consultation is to increase the ability of the childcare provider to successfully nurture the socioemotional health of all children. Once the CCEP consultant and provider agree to work together to make programmatic changes, the consultant takes the role of facilitator. The consultant gathers a great deal of information by asking questions, listening, and reflecting on the thoughts and feelings of the director, the staff, and, sometimes, the families. Program enhancements are suggested once problem identification has been completed. Creating change within childcare programs is the primary goal of programmatic consultation, and understanding how each party perceives the situation and involving them within an action plan is essential to that goal. The success of programmatic consultation relies heavily on the strength of the relationship developed between the consultant and provider(s).

LESSONS LEARNED FOR STATE- AND LOCAL-ECMHC PERSONNEL

Many lessons have been learned throughout the past decade of developing, implementing, and evaluating an ECMHC program in Michigan. Several of these lessons are shared next to support policy makers, administrators, and staff in their quest to develop and implement high-quality ECMHC programs in their own communities.

- Think early about evaluation. Use standardized, norm-referenced, socioemotional assessment tools. Have a strong data-collection system to remain accountable, to measure fidelity, and to help drive future funding.
- The contracts between the Department of Community Health and local program sites are very important. The contractual language clarifies expectations and commitment to carrying out the ECMHC program. The contract conveys the model, details the hiring/staffing commitment, describes accountability, and supports fidelity to the model.
- Strong state-level technical assistance to sites and consultants provides essential support, training, and resources. In addition to conveying and strengthening the program model, technical assistance builds relationships, trust, and connections between programs, consultants, and program administration. Having all parties working together and communicating regularly with one another facilitates model fidelity, program improvement, and development of the early childhood mental health system of care.
- Not limiting the number of consultation visits has been important to the CCEP's model. In the context of relationship-

based practice, this flexibility allows for individual differences and recognizes the importance of pace, timing, and cultural aspects of all those involved to bring about positive change.

- From the start, define the model as clearly as possible. In the CCEP, a mental health model is used, and people doing the work are required to have mental health experience.
- To ensure that consultants are effectively supported, it is critical for local-level consultants to have invested and involved administrative supervisors to support program fidelity and contractual fulfillment.
- Similarly, it is imperative for consultants to have access to regular, ongoing reflective supervision to maintain continuity and sustainability of services. In addition, reflective supervision contributes to the quality of consultation and helps to support consultants' efforts to work meaningfully with providers and parents toward effective outcomes.
- It is important to set up a workforce development plan for ECMHC because there are scarce resources for this field.

IMPLICATIONS FOR FUTURE ECMHC RESEARCH

While information is emerging about the components associated with effective ECMHC services, much remains to be learned about how these services specifically lead to improvements in child outcomes. This was evident within the results of the most rigorous evaluation of ECMHC to date (Gilliam, 2007). Study findings clearly indicate improvements in children's externalizing behaviors as a result of consultation services. However, the pathway to those changes remains unknown because corresponding improvements in teacher behavior or changes in classroom climate were not found, contrary to study hypotheses.

Focusing exclusively on child outcomes within the ECMHC process is clearly insufficient, as much has yet to be learned about how and why ECMHC works (Upshur et al., 2009). Multiple systems need to be targeted for change and evaluative data at the family, staff, and program levels to isolate the mechanisms of change that may lead to effective outcomes. Recent research has begun to identify specific staff (e.g., improvements in teachers' self-reported competence), program (e.g., reductions in program expulsions), and child outcomes (e.g., reduction in externalizing behaviors) associated with ECMHC (Alkon, Ramler, & MacLennan, 2003; Brennan et al., 2008; Perry et al., 2010). These findings need further replication within studies using experimental research methods (e.g., randomized controlled trials). Additional investigations also are needed on ECMHC that involve specified treatment approaches that have demonstrated efficacy (e.g., the use of the Incredible Years Teacher Training Program) (Webster-Stratton, 1994). Current research efforts and those in recent years have highlighted clear paths of needed research. The task at hand for evaluation research teams is to follow those promising paths in the next wave of research on ECMHC approaches.

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